

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
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ENROLLMENT / MEDICAL RECORD

Child's Name	Date of Birth
Mother's Name	Home Phone
Mother's Address	Work Phone
Father's Name	Home Phone
Father's Address	Work Phone
Family or Relative	Phone
Address	
Family Doctor	Phone
Family Dentist	Phone
In the event I am not available call _____ at _____ (phone #)	
In the case of emergency, where you are unable to reach the above number, you have my permission to contact another local licensed physician if our family physician is not available, or take my child to a hospital for emergency treatment.	
Signed _____ Date _____	

(over)

Special Health Problems: _____						
Daily or Weekly Medicines: _____						
Allergies: _____						
Immunizations: (Give month, day and year of each immunization)						
Polio	1. _____	2. _____	3. _____	4. _____	5. _____	
DTP/DT/DTaP	1. _____	2. _____	3. _____	4. _____	5. _____	
MMR	1. _____	2. _____				
<div style="border: 1px solid black; padding: 5px; width: fit-content;"> If given as single vaccines- record here. </div>	Measles	1. _____	2. _____			
	Mumps	1. _____				
	Rubella	1. _____				
HIB	1. _____	2. _____	3. _____	4. _____		
Hepatitis B	1. _____	2. _____	3. _____			
Other Immunizations: _____						
TB Skin Test _____ Positive _____ Negative _____						
(Date of last test)						